California Medicine

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EDITORIAL

Quality of Health Care

THE QUALITY OF HEALTH care rendered to patients has long been the subject of formal and informal discussion among practitioners of medicine. More recently this question as it applies to patients whose care is paid for by county, state or federal agencies has come under consideration in legislative bodies and other interested groups.

Historically the medical profession more than others has been concerned with the quality of training of its practitioners and the quality of care they have supplied. Indeed the Flexner Report, which was the source work for great improvements in medical education, beginning early in this century, grew out of the American Medical Association's efforts to raise the quality of care. The continuing devotion of the medical profession to medical care of high quality is expressed in many ways and carried forward by serviceable devices—among them the AMA Council on Medical Education for the approval of medical schools and internships, the Joint Committee on Accreditation of Hospitals which reviews the facilities and the organization for care given in hospitals, the residency review committees which approve residency programs under which young physicians receive their training, and locally the various committees set up by hospital staffs themselves for tissue review and utilization review, among others, as a way to maintain a constant survey of the quality of care and the proficiency of physicians.

The determination of quality in medical care is of course largely subjective, but evaluations that can be expressed in objective terms that mean as nearly as possible the same thing to all who use them are needed—more than ever, now that "third parties" are much in the medical care picture.

Attempts to arrive at such evaluations are going forward in many places. At the First National Congress on the Socio-Economics of Health Care, sponsored by the AMA, a physician suggested ways to arrive at better conclusions by more intensive and concerted application of assessment techniques already known and used[4]; a mechanical engineer put forward a plan for developing a mathematical index that would draw together the factors relating to the quality of medical care[2]; a representative of the United States Air Force described a method for determining the medical personnel needs in relation to various kinds of medical services in Air Force facilities.[3]

The California Medical Association's own Committee on the Role of Medicine in Society has been hard at work on the question, and we believe it timely to publish a thought-provoking report prepared by the Committee [see page 486]. It has been received by the Council and the House of Delegates. No official action has been taken on it and it is presented here, as it was received by the Council and the House, for information. It is the Committee's consensus that while "quality health care" means many things to many people it is still quite possible to define the term in a standard sense and determine whether quality care is being provided and to what extent.

At present, many physicians throughout California are voluntarily serving on hospital medical staff, foundation or Blue Shield utilization review committees not only to determine the nature and amount of medical care but to maintain high quality. Reviews of this kind serve to educate the attending physician in terms of future patient treatment and in no way are they a cost control or disciplinary function for private insurance or government-financed medical care programs. Admittedly the system is not a perfect one. Much more needs to be done in developing checks and

balances in quality control and utilization review. However, it is a start.

Certainly more specific guidelines need to be developed and the term "quality health care" needs to be defined so that it means the same thing to the providers of service, to patients, to insurance carriers and to governmental agencies. As to the need for guidelines and definitions, a case in point is a bill now before the California Legislature which authorizes the establishment of several prepaid medical pilot programs. The law would require that "such programs shall demonstrate different methods of providing health care services and shall emphasize methods of utilization review and preventive care, and shall provide incentive for using the most economical level of such care."[1]

There are pressing reasons for finding serviceable criteria for determining the quality and utilization of medical care, and we welcome the help and cooperation of insurers, of foundations, of Blue Shield, of governmental agencies—indeed of anyone who can contribute to a solution of this problem.

But we must not lose sight of the fact that the end purpose of these efforts is to make sure that the quality of the care of patients is kept high. Hence, the responsibility for appraising the adequacy of indices of quality and for determining how they are to be used in the patient's best interest is the responsibility, first and ultimate, of the medical profession.

REFERENCES

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